COMMUNICATION CIRCLES

Intake Form

Patient's name _____ Sex:_____

Birthdate: _____ Age: _____

MCO:_____Medicaid #: _____

Insurance Company: _____

Insured's Name:_____Insured's DOB:_____

Patient's Address:_____

Phone:_____ Cell: _____

Referred by: _____

School/Work Location: _____Grade:_____

Primary Care Doctor's name:_____

Address: _____

Fax Number: _____

Father’s full name: (if minor)_____

Mother’s full name: (if minor)_____

Language(s) spoken at home:_____

Statement of the problem (In your own words, what difficulty is the patient having with speech, language, or communication?)

_____

_____

_____

When was it first noticed?

_____

_____

_____

If the patient is nonverbal, can he or she activate a phone, iPad or tablet with his/her hand:

_____

_____

_____

Has the patient ever used an AAC (communication) device? If so, what type:

_____

_____